REPORT OF INCIDENT / INJURY

State Form 46009 (R2 / 8-07)

Reset Form

ADDRESSOGRAPH

The information in this document is confidential according to 45 CFR 160 and 164, IC 16-39, and 42 CFR Part 2.

INCIDENT INFORMATION *(for incident reported)*

Date of incident *(month, day, year)*	Time *(24 hour)*	Location of incident *(ward / area)*	Date of report *(month, day, year)*	Time *(24 hour)*

DETAILED INCIDENT LOCATION *(check one)*

☐	AR	Activity / Rec.	☐	CA	Clinic Area	☐	LR	Living Room	☐	RA	Ramp	☐	SW	Sidewalk	☐	WV	Work / Vocational
☐	BA	Bath Room	☐	DR	Dining Room	☐	LO	Lobby	☐	RO	Roadway	☐	SM	Smoking	☐	OR	Other
☐	BE	Bed Room	☐	HA	Hall	☐	NS	Nurse Sta. / Off.	☐	SH	Shop	☐	ST	Stairs	☐	OF	Off Grounds
☐	CL	Classroom	☐	KI	Kitchen	☐	PL	Parking Lot	☐	SE	Seclus / Time Out	☐	VE	Vehicle	☐	UN	Unknown

INCIDENT TYPE *(** alleged)*

☐	AP	Alcohol Poss / Con	☐	CU	Contact / Unintentional **	☐	FM	Failure / Medical Equip	☐	MI	Medicine Incid / ADR	☐	TH	Theft **			
☐	AV	Attack / Verbal **	☐	DP	Drug Possess. / Con	☐	FR	Failure / Follow MD/RN Order	☐	OH	Overheating / Heat Prost	☐	TR	Trespass			
☐	AW	AWOL / Elopement	☐	EB	Exposure/Blood/Body Fluids	☐	FU	Fire / Unintentional	☐	PD	Property Destruction	☐	VA	Vehicle Accident			
☐	BM	Behavior Mgmt	☐	EC	Expos / Dangerous Chem	☐	IG	Ingestion / Foreign Object	☐	SA	Suicide Attempt / Gesture	☐	OR	Other			
☐	CH	Choking	☐	EF	Environmental Factors	☐	IN	Injury / Unknown Origin	☐	SE	Seizure						
☐	CI	Contact / Intentional **	☐	ER	Equipment Related	☐	IS	Illness / Sudden Onset	☐	SI	Self-Injurious Behavior						
☐	CO	Contraband	☐	FA	Fall	☐	LI	Lifting	☐	SS	Severe Sunburn						
☐	CS	Contact / Sexual **	☐	FI	Fire / Intentional	☐	ME	Medication Error	☐	ST	Suicide Threat						

INFORMATION REGARDING INDIVIDUALS INVOLVED IN INCIDENT *(use letters from categories below)*

Person's Category	Person's Role	I.D. Number	Name	Age	Diag.

Person Category	Person's Role	Diagnosis
CE Contract Employee	PP Perpetrator	MI Mentally Ill
EE Employee	VI Victim	DD Developmentally Disabled
DO DOC Offender	WI Witness	DA Drug / Alcohol
PA Patient / Client		OR Other
VI Visitor		
VO Volunteer		

INJURY *(check applicable categories)*

Type of Injury

☐	AB	Abrasion
☐	BI	Bite
☐	BF	Break / Fracture
☐	BU	Burn
☐	CO	Contusion / Bruise
☐	EP	Bloody Nose
☐	LA	Laceration / Cut
☐	MI	Muscle Injury
☐	NS	Needle Stick
☐	PS	Poss Break / Fracture
☐	PU	Puncture
☐	SC	Scratch
☐	ST	Sting
☐	SB	Sunburn
☐	SW	Swelling
☐	OR	Other
☐	NO	No Injury

Body Part Affected

☐	MT	Mouth / Teeth
☐	RE	Right Eye
☐	LE	Left Eye
☐	RR	Right Ear
☐	LR	Left Ear
☐	NO	Nose
☐	HF	Head / Face
☐	NE	Neck
☐	CH	Chest
☐	AD	Abdomen
☐	BK	Back
☐	GE	Genitalia
☐	BU	Buttocks
☐	RA	Right Arm / Hand
☐	LA	Left Arm / Hand
☐	FI	Fingers
☐	RL	Right Leg / Foot
☐	LL	Left Leg / Foot
☐	TO	Toes
☐	OR	Other

Apparent Cause

☐	AM	Animal
☐	CK	Chemical / External
☐	CN	Chemical / Internal
☐	EV	Environmental Factors
☐	EQ	Equipment
☐	FU	Furnishings
☐	IN	Insect
☐	LI	Lifting
☐	MD	Medical Devices
☐	NS	Non-staff person
☐	OT	Other Patient / Client
☐	SE	Seizure
☐	SI	Self - intentional
☐	SU	Self - unintentional
☐	SP	Staff Person
☐	WI	Water Intoxication
☐	OR	Other
☐	UN	Unknown / Unknown Origin

Treatment Given

☐	NT	No Treatment
☐	FA	First Aid
☐	DX	Diag / Exam / Tests
☐	MF	More Than First Aid
☐	RE	Referral

Treatment Location

☐	IN	Incident Location
☐	ON	On Grounds Med. Facility
☐	OF	Off Grounds Med. Facility

Treatment Given By

☐	OR	Other Facility Staff
☐	FS	Facility Nurse
☐	FP	Facility Physician
☐	NF	Non-facility Staff

DESCRIPTION OF INCIDENT

Brief, essential information, no opinions/conclusions, no clients names

Signature	Title	Date *(month, day, year)*

Continued on reverse side

NURSING COMMENTS

Brief, essential information, no opinions/conclusions, no client names

Signature	Date signed *(month, day, year)*

PHYSICIAN COMMENTS

Brief, essential information, no opinions/conclusions, no client names

Signature	Date signed *(month, day, year)*

INTERNAL NOTIFICATIONS *(if applicable)*

Supervisor notified / reviewed	Nurse notified / reviewed	Physician notified / reviewed	Comment
Date notified *(month, day, year)*	Date notified *(month, day, year)*	Date notified *(month, day, year)*	
Time notified	Time notified	Time notified	Security notified ☐ Yes ☐ No

AGENCIES NOTIFIED OF THE INCIDENT *(see listing below)*

Agency Type	Name of Agency *(use only if not listed)*	Date *(month, day, year)*	Time	Name of Person Notified	Name of Person Who Notified

AGENCY LIST

AP	Adult Protect Service	DH	Dept of Health	NK	Next of Kin	SP	State Police
CA	Child Welfare	DM	Div. of Mental Health & Addiction	GM	Guardian	SS	Secret Service
DF	Div. of Family Resources	DA	Div. of Aging & Rehabilitation	HC	Health Care Rep	OR	Other